DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 108

MANAGED CARE
QUALITY ASSURANCE

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Subchapter 2

Network Adequacy for Managed Care

MANAGED CARE
QUALITY ASSURANCE

Subchapter 5

Quality Assurance for Managed Care Plans

Subchapter 1 reserved

Subchapter 2

Network Adequacy for Managed Care

37.108.201 DEFINITIONS The following definitions, in addition to those contained in 33-36-103, MCA, apply to this chapter:

(1) "Access plan" means a document filed by a health carrier with the department that complies with the standards set forth in ARM 37.108.205 through 37.108.207 and 33-36-201, MCA.

(2) "Advanced practice registered nurse" means a nurse midwife, a nurse anesthetist, a nurse practitioner, or a clinical nurse specialist.

(3) "Geographic service area" means a geographic area of Montana in which a health carrier has a network that has been deemed adequate by the department.

(4) "Mid-level provider" means a physician assistant-certified or an advanced practice registered nurse.

(5) "Non-urgent care with symptoms" means care required for an illness, injury, or condition with symptoms that do not require care within 24 hours to prevent a serious risk of harm but do require care that is neither routine nor preventive in nature.

(6) "Primary care provider (PCP)" means a physician, mid-level provider, federally qualified health center or rural health clinic as defined in ARM 46.12.1708, migrant health center or other community-based provider that is designated by a health carrier to supervise, coordinate, or provide initial or continuing care to an enrollee, and if required by the health carrier, initiate a referral for specialty care services rendered to the enrollee.

(7) "Specialty provider" or "specialist" means a physician or other provider whose area of specialization is an area other than general medicine, family medicine, general internal medicine or general pediatrics. A provider whose area of specialization is obstetrics and/or gynecology may be either a PCP or a specialist within the meaning of this rule.

(8) "Urgent care" means those health care services that are not emergency services but that are necessary to treat a condition or illness that could reasonably be expected to present a serious risk of harm if not treated within 24 hours. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-103 and 33-36-105, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 02 through 04 reserved

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37.108.205 ACCESS PLAN FILING AND REVIEW GUIDELINES

(1) When a health carrier submits a proposed access plan to the department for review and approval, the department will either approve, disapprove, or request additional information on the proposed plan within 60 calendar days. The department has a total of 60 calendar days to review and issue a decision concerning any proposed access plan, not including any 30 calendar day response period that may be granted a health carrier proposing the plan. The department may grant up to two 30 day response periods during the review of each access plan.

(2) During the departmental review of its proposed access plan, a health carrier must respond to a departmental request for information within 30 calendar days after the date of the request. If the response remains incomplete, the department may grant the health carrier a second 30 calendar day period within which to submit a complete response. If, after two departmental requests for information, the health carrier fails to provide information that the department deems sufficient to satisfy its requests, the access plan will be disapproved and the health carrier will be required to submit a new proposed access plan prior to enrolling initial or additional enrollees.

(3) The total number of days allowed for the review of a given proposed access plan may not exceed 120 calendar days, including both time spent by the department in review of the proposed plan and any time granted to a health carrier to respond to departmental requests for additional information. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.206 ACCESS PLAN UPDATES (1) Health carriers shall be responsible for monitoring the status of their networks and must submit an updated access plan to the department within 30 calendar days after a significant change in the status of their network. For the purposes of this rule, a significant change is a change in the composition of a health carrier's provider network or a change in the size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier's network non-compliant with one or more of the network adequacy standards set forth at ARM 37.108.215, 37.108.219 and 37.108.227. If the revised access plan is not submitted within 30 calendar days after the material change in network status occurs, the health carrier must cease enrolling new recipients in the affected geographic service area until the revised access plan is approved by the department. Review of the revised access plan is subject to the procedures and consequences outlined in ARM 37.108.205.

(2) In addition to the requirement in (1) above, the health carrier must submit an updated access plan to the department by at least 2 years after the date the carrier's access plan was last approved by the department. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.207 ACCESS PLAN SPECIFICATIONS (1) In addition to meeting the requirements of 33-36-201(6), MCA, an access plan for each health carrier offered in Montana must describe or contain the following:

(a) a list of participating providers which describes the type of provider, their specialty or credentials, and also their names, business addresses, zip codes, and phone numbers. The list must indicate which providers are accepting new patients;

(b) the health carrier's policy for making referrals within and outside of the network including, at a minimum, the health carrier's method for complying with each of the standards set forth in ARM 37.108.228, 37.108.229 and 37.108.235;

(c) the health carrier's process for monitoring on a periodic basis the need for and satisfaction with health care services of the enrolled population and ensuring on an ongoing basis, the sufficiency of the network to meet those needs and, at a minimum, the health carrier's methods for complying with each of the standards set forth in ARM 37.108.240;

(d) the health carrier's policy to address the needs of enrollees with limited English proficiency and/or illiteracy, those with diverse cultural and ethnic backgrounds, and those with physical and mental disabilities, in order to insure that these characteristics do not pose barriers to gaining access to services. The policy shall, at a minimum, describe the health carrier's methods for complying with each of the standards set forth in ARM 37.108.236; and

(e) a copy of the health benefit plan's booklet or policy or certificate of coverage, a summary of benefits for each policy (if available), the list of network providers for each policy, and any other important information about the health carrier's services and features which must be provided by the health carrier to either potential enrollees or covered enrollees. This information must be presented in language that is comprehensible to the average layperson. The information to be provided includes, but is not limited to:

(i) a listing of participating providers, as described in (1)(a) above;

(ii) a summary description of the health carrier's standards for provider credentials and methodology for reviewing providers' credentials on an ongoing basis required by ARM 37.108.216;

(iii) the procedures in place for selecting and changing providers;

(iv) a copy of the information filed with the commissioner of insurance detailing the health carrier's benefits, including a comprehensive list of covered and non-covered services;

(v) the health carrier's policy regarding enrollee responsibility for co-insurance, copayments, and deductibles;

(vi) a detailed description of the health carrier's procedures along with authorization for specialty care that comply with ARM 37.108.228, a schedule of the fees, including co-insurance, copayments and deductibles, for which an enrollee will be responsible;

(vii) policies pertaining to approval of and access to emergency services that meet the requirements of ARM 37.108.214;

(viii) telephone numbers and procedures for contacting an authorized representative of the health carrier who can facilitate review of post-evaluation or post-stabilization services required immediately after receipt of emergency services;

(ix) a description of the health carrier's grievance procedures, including specific instructions and guidelines for filing and appealing grievances;

(x) a policy regarding use of and payment for in-network services; and

(xi) a policy regarding use of and payment for out-of-network services.

(f) the health carrier's method of providing and paying for emergency screening and services 24 hours a day, 7 days a week, in accordance with ARM 37.108.214;

(g) a process for enabling enrollees to change primary care professionals that meets the standards of ARM 37.108.235;

(h) a process for transfer of enrollees to other providers must include a provision for transitional care as described in ARM 37.108.229;

(i) the process used to address and correct instances where a health carrier has an insufficient number or type of participating providers accessible to enrollees to provide a covered benefit. This process must comply with the requirements of ARM 37.108.219 and 37.108.220; and

(j) the health carrier's procedures for complying with geographic accessibility requirements as outlined in ARM 37.108.219 and 37.108.220. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.208 ACCESS CRITERIA (1) The department will utilize the criteria set forth in this chapter and Title 33, chapter 36, MCA to determine whether the network maintained by a health carrier offering a managed care plan in Montana is sufficient in numbers and type of providers. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 09 through 13 reserved

37.108.214 MANDATORY COVERAGE (1) The following must be reimbursed without regard to either prior authorization or the contractual relationship between the health carrier and the provider:

(a) emergency services as defined in 33-36-103, MCA;

(b) covered services that do not meet the criteria for emergency services, but which were medically necessary and immediately required because an unforeseen illness, injury or condition occurred when the enrollee was outside the health carrier's geographic service area and could not reasonably access services through the health carrier's network of providers; and

(c) renal dialysis, if covered, that is provided while the enrollee is outside the health carrier's service area for no more than 30 calendar days per year. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105, 33-36-201 and 33-36-205, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.215 PROVIDER-ENROLLEE RATIO REQUIREMENTS (1) In order to be deemed adequate, a health carrier's network must include one mid-level PCP per 1,500 projected enrollees or one physician PCP per 2,500 projected enrollees. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.216 VERIFICATION OF PROVIDER CREDENTIALS (1) Each health carrier shall establish and describe in its access plan the criteria utilized to review the credentials of the providers in its network. A health carrier must require a provider's credentials to be reviewed prior to the health carrier employing or entering into contractual relationship with a provider and a provider's credentials are to be reverified at least every 3 years thereafter. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 17 and 18 reserved

37.108.219 GEOGRAPHIC ACCESS CRITERIA (1) In order to be deemed adequate, a provider network must fulfill all access criteria of the rules in this chapter within the following geographic restrictions:

(a) to the extent that services are covered by the health carrier, the health carrier must have an adequate network of primary care providers; a hospital, critical access hospital, or medical assistance facility; and a pharmacy that is located within a 30 mile radius of each enrollee's residence or place of work, unless:

(i) the usual and customary travel pattern of the general population within the service area to reach health care providers is further, and if the fact that the usual and customary travel pattern exists is documented by the health carrier; or

(ii) the provider is available but does not meet the health carrier's reasonable credentialing requirements; and

(b) if no qualified provider for a service covered by the plan exists within a 30 mile radius of an enrollee's residence or place of work, the health carrier must document how covered services will be provided at no additional charge to enrollees through referrals to qualified providers outside the 30 mile radius.

(2) Enrollees may, at their discretion, select participating primary care providers located farther than 30 miles from their homes and/or places of business.

(3) When an eligible employee in a group health plan neither resides nor works within a 30 mile radius of the network established pursuant to (1), the network may be deemed adequate subject to the following conditions:

(a) Insured employees living and working outside the 30 mile radius of the primary place of work of their employer, as well as their dependents, may not be penalized either in benefits or by being required to travel outside the 30 mile radius from their own place of work to receive routine treatment typically provided by a primary care provider.

(b) The health carrier may require employees to utilize a network primary care provider for referrals, including for referrals for routine treatment provided by a primary care provider. If such a requirement is imposed, access to the network primary care provider must be available to the insured by phone at no cost to the insured. A toll free number to the health carrier would satisfy this requirement.

(c) At the time of initial selection or the renewal of a managed care plan, the maximum number of eligible employees residing and working outside the 30 mile radius of the primary place of work may not exceed the following:

(i) for groups with two to five employees, one;

(ii) for groups with six to 15 employees, two;

(iii) for groups with 16 to 30 employees, three, and

(iv) for groups with 30 or more employees, 10% of the employees. (History: 33-36-105, MCA; IMP, 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99; AMD, 2005 MAR p. 1296, Eff. 7/15/05.)

37.108.220 EXCEPTIONS TO GEOGRAPHIC ACCESS CRITERIA

(1) The department may grant exceptions to the geographic accessibility standard in ARM 37.108.219 if good cause to do so exists.

(2) Good cause includes but is not limited to the circumstance where the health carrier has documented a good faith effort to negotiate a contract with local providers but has failed to reach an agreement within 60 days after the offer of a written contract from the health carrier. A good faith effort means an honest effort with the intent to deal fairly with providers and includes offering terms and conditions at least as favorable as those offered to other entities providing the same or similar services. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.221 SERVICE AREAS (1) A network's service area may encompass more than one geographic service area provided the network in all such areas meets the network adequacy criteria. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 22 through 26 reserved

37.108.227 MAXIMUM WAIT TIMES FOR APPOINTMENTS (1) An adequate network must meet the following criteria for all enrollees:

(a) emergency services must be available and accessible at all times;

(b) urgent care appointments must be available within 24 hours;

(c) appointments for non-urgent care with symptoms must be available within 10 calendar days;

(d) appointments for immunizations must be available within 21 calendar days; and

(e) appointments for routine or preventive care must be available within 45 calendar days. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.228 REFERRAL AND SPECIALTY CARE REQUIREMENTS

(1) Procedures for referrals must be clearly outlined in the access plan, in literature provided to all enrollees, and in literature or contracts provided to all participating providers.

(2) Women and adolescent females who do not designate a gynecological health care provider as their PCP must be allowed direct access (without prior authorization or referral from a PCP) to a participating provider whose area of specialization is gynecology for routine gynecological care no less frequently than one time per year.

(3) Pregnant females must be allowed direct access, without prior authorization or referral from a PCP, to a participating provider whose area of specialization is obstetrics.

(4) An enrollee must be allowed to designate a participating pediatrician, family practice physician, or, if the health carrier allows a mid-level provider to be a PCP, a mid-level provider specializing in primary care of children as the PCP for the enrollee's children and/or adolescents who are covered by the health carrier.

(5) The access plan must include a process to address and correct instances where a health carrier has an insufficient number or type of participating providers accessible to enrollees to provide a covered benefit. In these instances, the health carrier must ensure that covered services are provided at no greater cost to the enrollee than if the services were obtained from a participating provider.

(6) The access plan must include policies and procedures by which an enrollee with a condition that requires ongoing care from a specialist may obtain a standing referral to a participating specialty provider. For purposes of this rule, standing referral means a referral for ongoing care to be provided by a participating specialty care provider that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan approved by the carrier and developed by the enrollee's PCP, the specialty provider, and the enrollee. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.229 CONTINUITY OF CARE AND TRANSITIONAL CARE

(1) A health carrier must allow the following new enrollees to continue to receive services from their previous providers for the time periods noted below, so long as those providers agree to abide by the payment rates, credentialing, referral process, quality-of-care standards and protocols, and reporting standards that apply to comparable participating providers:

(a) a new enrollee with a life-threatening, disabling or degenerative condition may obtain care from their previous provider for a period of 60 days, beginning the date of the enrollee's enrollment with the health carrier;

(b) a new enrollee who has received a diagnosis of terminal illness with life expectancy of less than 6 months, may continue to obtain care from their previous provider until death if it occurs prior to the end of the 6 month period, or, if it does not, for a period of 6 months from the date of the enrollee's enrollment with the health carrier, unless the period is extended after the enrollee's medical needs and the appropriateness of requiring a transition to a participating provider are reassessed. Such a reassessment must be conducted at or before the end of the 6 month period by the health carrier for such a terminally ill enrollee; and

(c) a new enrollee in the second or third trimester of pregnancy may obtain care from their previous provider through the completion of postpartum care.

(2) A health carrier must allow enrollees with the medical conditions described in (1)(a) through (1)(c) above to continue to receive services from their existing providers when their provider's contract is terminated by the carrier without cause or when the provider voluntarily terminates their contract with the carrier, so long as those providers agree to abide by the payment rates, credentialing, referral process, quality-of-care standards and protocols, and reporting standards which apply to comparable participating providers. The time periods during which such continued services are allowed are the same as those specified in (1)(a) through (1)(c) above, with the exception that, for the conditions described in (1)(a) and (1)(b), the time period begins on the date the provider's contract is terminated, rather than the date of the enrollee's enrollment with the health carrier.

(3) A health carrier may not hold an enrollee covered by this rule responsible for any additional payments, copayments, co-insurance or deductibles beyond what would be required if the services were provided by a participating provider. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99; AMD, 2000 MAR p. 2432, Eff. 9/8/00.)

Rules 30 through 34 reserved

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37.108.235 SELECTING AND CHANGING PROVIDERS (1) Enrollees must be allowed to change primary care providers at least once per benefit year.

(2) The health carrier will monitor the frequency of enrollees' requests to change primary care providers and shall have in place a policy to address situations in which a provider has patient turnover rates that are significantly higher than the average rate within the health carrier's network. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.236 REMOVAL OF BARRIERS TO ACCESS (1) The health carrier must have a policy in place to address the needs of enrollees with limited English proficiency and/or illiteracy, those with diverse cultural and ethnic backgrounds, and those with physical and mental disabilities, in order to insure that these characteristics do not pose barriers to gaining access to services. This policy shall, at a minimum, describe the health carrier's methods for providing the following:

(a) interpreter services to allow effective communication regarding treatment, medical history and health education;

(b) appropriate and sufficient personnel, physical resources and equipment to meet the basic health care needs of these enrollees; and

(c) education to providers and other employees about the needs of these covered persons. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 37 through 39 reserved

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37.108.240 MONITORING THE NETWORK (1) The health carrier must establish methods for periodically assessing the sufficiency of the network to meet the health care needs of covered persons as well as assessing their satisfaction with services. The following must be included in this assessment:

(a) changes in volume of specialty services needed;

(b) changes in number of primary care providers needed;

(c) other changes in health care utilization that might indicate changes in the health status of covered persons;

(d) enrollee satisfaction with billing and record keeping;

(e) provider satisfaction with billing and record keeping;

(f) enrollee satisfaction with educational materials available to them;

(g) enrollee satisfaction with 24-hour access to medical advice and services;

(h) enrollee satisfaction with the referral process; and

(i) provider satisfaction with the referral process. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.241 LETTERS OF INTENT (1) In order to demonstrate that its network is adequate, a health carrier may utilize letters of intent from individual providers with whom it does not yet have a contract, so long as the providers do not constitute more than 15% of the total network. If letters of intent from providers are utilized, within 6 months after the access plan is submitted to the department the health carrier must submit to the department verification that it has an adequate network. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-201, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.242 RESPONSIBILITY FOR CONTRACTED SERVICES (1) A health carrier offering a managed care plan that uses a contractual arrangement to provide services to covered persons remains responsible for meeting the requirements of this chapter, including documentation requirements. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

Rules 43 through 49 reserved

37.108.250 CORRECTIVE ACTION (1) The department may recommend corrective action to the health carrier in the event the health carrier fails to comply with the network adequacy requirements set forth in these rules.

(2) If a health carrier fails to implement adequate corrective action, the department will provide the commissioner of insurance with documentation of the network's inadequacy. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105, MCA; NEW, 1999 MAR p. 2052, Eff. 9/24/99.)

37.108.251 APPEAL FROM DEPARTMENT DECISION (1) If a health carrier or health care provider is aggrieved by any decision made by the department pursuant to Title 33, chapter 36, part 2, MCA, and these rules, the aggrieved party may request a hearing before the department by submitting the request in writing to the department's Quality Assurance Division, Office of Fair Hearings, 616 Helena Avenue, Steamboat Block, P.O. Box 202953, Helena, MT 59620-2953.

(2) The hearing will be conducted in accordance with the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, MCA and ARM 1.3.211 through 1.3.225 and ARM 1.3.230 through 1.3.233. For purposes of such hearings, the department hereby adopts and incorporates by reference ARM 1.3.211 through 1.3.225 and ARM 1.3.230 through 1.3.233, which contain the attorney general's model rules for contested cases. Copies of these rules may be obtained from the department's Office of Legal Affairs, P.O. Box 202951, Helena, MT 59620-2951.

(3) The provisions of ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings. (History: Sec. 2-4-201 and 33-36-105, MCA; IMP, Sec. 2-4-201 and 33-36-105, MCA; NEW, 1999 MAR p. 2637, Eff. 9/24/99.)

Subchapter 3

Independent Review of Health Care Decisions

37.108.301 INDEPENDENT REVIEW OF HEALTH CARE DECISIONS: DEFINITIONS The following definitions, in addition to those contained in 33-37-101, MCA, apply to this chapter:

(1) "Expedited review" means an accelerated appeal of an adverse determination made by a health carrier or managed care entity involving an enrollee with urgent medical needs whose life or health would be seriously threatened by the delay of a standard appeals process.

(2) "Independent review organization" means a network of peers conducting an independent review of an adverse determination made by a health carrier or managed care entity.

(3) "Internal appeals process" means a process established by a health carrier or managed care entity by which a party affected by an adverse determination made by a health carrier or managed care entity may appeal the adverse decision within the deciding agency. (History: Sec. 33-37-105, MCA; IMP, Sec. 33-37-101 and 33-37-105, MCA; NEW, 1999 MAR p. 2880, Eff. 12/17/99; AMD, 2003 MAR p. 1662, Eff. 8/1/03.)

Rules 02 through 04 reserved

37.108.305 INDEPENDENT REVIEW OF HEALTH CARE DECISIONS: PEER REVIEW PROCESS (1) A health carrier or managed care entity and an enrollee may agree on a peer to conduct an independent review, as specified in these rules, of any adverse determination made by the health carrier or managed care entity. If the health carrier or managed care entity and the enrollee are unable to agree on a peer to conduct the independent review, then the health carrier or managed care entity shall forward the case file to the independent review organization designated by the department.

(2) The peer or the independent review organization designated by the department shall ensure that the case file contains the information listed in 33-37-102(2)(a) through (2)(d), MCA, and that it otherwise is eligible for independent review.

(3) In the case of routine health care decisions, the peer or independent review organization shall notify the health carrier or managed care entity, the enrollee, and the health care provider of its decision within 30 calendar days after receiving the case file. The notification shall include a statement of the basis for the decision and shall list the evidence the peer or independent review organization considered in making the decision. If the peer or independent review organization requires additional time to complete its review, it shall request an extension in writing from the department. The request for extension shall include the reasons for the request and state the specific time the review is expected to be completed.

(4) In the case of expedited review, the enrollee's health care provider must certify in writing, facsimile, or by electronic mail the need for the expedited review. Within 72 hours from the date the request for expedited review is received, the peer or independent review organization shall notify the health carrier or managed care entity, the enrollee, and the health care provider of its decision. The notification shall include a statement of the basis for the decision and shall list the evidence the peer or independent review organization considered in making the decision.

(5) A peer or independent review organization may not review any adverse determination in which the peer or independent review organization has an interest in the outcome. The peer or independent review organization must notify the health carrier or managed care entity and enrollee if there is a potential conflict of interest. The peer or independent review organization may not review any adverse determination which involves a potential conflict of interest unless the health carrier or managed care entity and enrollee provide a written acknowledgment of the conflict and waiver.

(6) A health carrier or managed care entity or its agent that provides medicaid-funded or any other publicly funded health care-related services is exempt from this peer review process for adverse determinations concerning clients covered by those programs. (History: Sec. 33-37-105, MCA; IMP, Sec. 33-37-102 and 33-37-103, MCA; NEW, 1999 MAR p. 2880, Eff. 12/17/99; AMD, 2003 MAR p. 1662, Eff. 8/1/03.)

37.108.306 INDEPENDENT REVIEW OF HEALTH CARE DECISIONS: CONFIDENTIALITY (1) All health care information provided to a peer or independent review organization is confidential and is subject to the provisions of Title 50, chapter 16, MCA, and 33-19-306, MCA. (History: Sec. 33-37-105, MCA; IMP, Sec. 33-37-102 and 33-37-103, MCA; NEW, 1999 MAR p. 2880, Eff. 12/17/99.)

Rules 07 through 09 reserved

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37.108.310 INDEPENDENT REVIEW OF HEALTH CARE DECISIONS: NOTICE OF ADVERSE DETERMINATION AND INDEPENDENT REVIEW RIGHTS (1) A health carrier or managed care entity shall notify an enrollee and the health care provider of any adverse determination:

(a) within 10 calendar days from the date the decision is made if the decision involves routine medical care; or

(b) within 48 hours from the date the decision is made, excluding Sundays and holidays, if the decision involves a medical care determination which qualifies for expedited review.

(2) The notice shall:

(a) be printed in clear legible type using a font of at least 12 point size;

(b) be written using a format and language which can be understood by a person who has no more than an eighth grade education;

(c) explain the reasons for the adverse determination;

(d) provide the enrollee with instructions on the process necessary to initiate an appeal or independent review; and

(e) inform the enrollee that an expedited review process is available and explain how an enrollee may initiate an expedited review.

(3) If an internal appeal process exists, the notice shall:

(a) inform the enrollee of the enrollee's right to appeal any adverse determination by requesting an internal review within 180 days after the date the adverse decision is made; and

(b) notify the enrollee, once the internal appeals process has been exhausted, of the enrollee's right to seek an independent review of any adverse determination within 60 days after the date the internal review decision is made.

(4) If an internal appeal process does not exist, the notice shall inform the enrollee of the enrollee's right to seek an independent review of any adverse determination within 180 days after the date the adverse decision is made. (History: Sec. 33-37-105, MCA; IMP, Sec. 33-37-102, MCA; NEW, 1999 MAR p. 2880, Eff. 12/17/99; AMD, 2003 MAR p. 1662, Eff. 8/1/03.)

Rules 11 through 14 reserved

37.108.315 INDEPENDENT REVIEW OF HEALTH CARE DECISIONS: INTERNAL APPEALS PROCESS (1) If a health carrier or managed care entity has an internal appeals process in place, the internal appeals process provided by the health carrier or managed care entity must be exhausted before the enrollee or the enrollee's authorized representative can submit a decision for independent review, unless:

(a) the internal appeals process is not completed within 60 calendar days from the date the request for appeal is received, in which case the internal appeals process will be interrupted and the case forwarded for independent review; or

(b) the health care treatment decision results in a serious threat to the health or threatens the life of the enrollee, in which case upon certification by the health care provider as defined in (1)(b)(i), the internal appeals process will be bypassed and the matter shall immediately be submitted for expedited review.

(i) If the enrollee's health care provider determines that the adverse determination involves a condition which seriously threatens the life or health of the enrollee, the enrollee's health care provider shall certify in writing, facsimile or by electronic mail that the life or health of the enrollee would be seriously threatened by the delay of an internal appeals process.

(2) The health carrier or managed care entity shall maintain written records of all requests for appeal and shall retain all related data for a period of three years unless a claim, audit, or litigation involving the records and data is pending, in which case the records and data must be retained until the claim, audit, or litigation is finally resolved, or for three years, whichever is longer.

(3) The peer or independent review organization shall retain all records and data generated by the peer or independent review organization for the purposes of completing the review for no less than three years, unless a claim, audit or litigation is pending, in which case the records or data shall be retained until the claim, audit or litigation is finally resolved or for three years, whichever is longer.

(4) The department shall have reasonable access to the records and data for quality assurance purposes, to perform an evaluation of the independent review process, or for any other lawful purpose of the department. (History: Sec. 33-37-105, MCA; IMP, Sec. 33-37-102, MCA; NEW, 1999 MAR p. 2880, Eff. 12/17/99; AMD, 2003 MAR p. 1662, Eff. 8/1/03.)

Subhapter 4 reserved

Subchapter 5

Quality Assurance for Managed Care Plans

37.108.501 PURPOSE (1) The purpose of these rules is to implement the quality assurance provisions of the Montana Managed Care Plan Network Adequacy and Quality Assurance Act specified in Title 33, chapter 36, part 3, MCA. These rules establish mechanisms for the department to evaluate quality assurance activities of health carriers providing managed care plans in Montana. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-102, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.502 DEFINITIONS The following definitions, in addition to those contained in 33-36-103, MCA, apply to this subchapter:

(1) "HEDIS" means health plan employer data and information set, a standardized set of performance measures used by the national committee for quality assurance to assess and report on quality assurance activities of offered managed care plans. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

Rules 03 and 04 reserved

37.108.505 QUALITY ASSURANCE STRUCTURE AND ACCREDITATION

(1) The health carrier shall appoint, prior to commencing operation, a medical physician licensed to practice in the state of Montana to advise, oversee, and actively participate in the implementation and operation of the quality assurance program.

(2) The health carrier may delegate quality assurance activities. The health carrier shall retain responsibility for the performance of all delegated activities and shall develop and implement review and reporting requirements to assure that the delegated entity performs all delegated quality assurance activities.

(3) A health carrier whose managed care quality assurance plan has been accredited by a nationally recognized accrediting organization shall initially provide a copy of the accreditation certificate or outcome report and the accrediting standards used by the accrediting organization to the department.

(a) If the department finds that the standards of the nationally recognized accrediting organization meet or exceed the department's standards, the department will approve the health carrier's quality assurance program.

(b) After approval by the department, the accredited health carrier shall provide proof of its continued accreditation annually to the department.

(c) An accredited health carrier whose quality assurance plan is approved by the department is not required to comply with ARM 37.108.505. If the accredited health carrier offers a closed or combination managed care plan, the health carrier must comply with ARM 37.108.510 and 37.108.515. All accredited health carriers, regardless of their offering of closed, combination, or open plans, must comply with ARM 37.108.507, 37.108.515, 37.108.516 and 37.108.520.

(d) The department will maintain a list of its approved accrediting organizations whose standards have been determined by the department to meet or exceed the department's quality assurance standards. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-302, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.506 WRITTEN DESCRIPTION OF QUALITY ASSESSMENT PLAN (1) The health carrier shall implement a written quality assessment plan that is evaluated annually and updated as necessary. The plan must be submitted to the department by October 1 of each year. The plan must describe:

(a) the plan's mission, goals, and objectives;

(b) the plan's organizational structure and the job titles of the personnel responsible for quality assessment;

(c) the scope of the quality assessment plan's activities, including:

(i) specific diagnoses, conditions, or treatments targeted for review to improve health care services and health outcomes;

(ii) mechanisms to evaluate enrollees' health and health care services in relation to current medical research, knowledge, standards, and practices;

(iii) communication processes by which the findings generated by the quality assessment program are communicated to providers and consumers to improve the health of enrollees; and

(iv) mechanisms to evaluate the service performance of the health carrier and primary care physicians.

(2) The written quality assessment plan must be signed by the health carrier's corporate officer certifying that the plan meets the department's requirements.

(3) The department and each health carrier will meet annually to review and approve the written quality assessment plans and their outcomes. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-302, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.507 COMPONENTS OF QUALITY ASSESSMENT ACTIVITIES

(1) Annually, the health carrier shall evaluate its quality assessment activities by using the following HEDIS year 2005 measures:

(a) childhood immunization;

(b) breast cancer screening;

(c) cervical cancer screening;

(d) comprehensive diabetes care; and

(e) HEDIS/consumer assessment of health plan survey (CAHPS) for adults.

(2) The health carrier shall record organizational components that affect accessibility, availability, comprehensiveness, and continuity of care, including:

(a) referrals;

(b) case management;

(c) discharge planning;

(d) appointment scheduling and waiting periods for all types of health care services;

(e) second opinions, as applicable;

(f) prior authorizations, as applicable;

(g) provider reimbursement arrangements that contain financial incentives that may affect the care provided; and

(h) other systems, procedures, or administrative requirements used by the health carrier that affect the delivery of care.

(3) The health carrier may meet the requirements in (2) by submitting information to the department regarding network adequacy as specified in ARM 37.108.201, et seq., as long as the information is consistent with what is required in (2).

(4) The department adopts and incorporates by reference the HEDIS year 2005 measures for the categories listed in (1)(a) through (e). The HEDIS year 2005 measures are developed by the national committee for quality assurance and provide a standardized mechanism for measuring and comparing the quality of services offered by managed care health plans. Copies of HEDIS 2005 measures are available from the National Committee for Quality Assurance, 2000 L Street NW, Suite 500, Washington, DC 20036 or on the internet at www.ncqa.org. (History: 33-36-105, MCA; IMP, 33-36-105 and 33-36-302, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01; AMD, 2002 MAR p. 954, Eff. 3/29/02; AMD, 2003 MAR p. 1662, Eff. 8/1/03; AMD, 2004 MAR p. 1406, Eff. 6/18/04; AMD, 2005 MAR p. 1296, Eff. 7/15/05.)

Rules 08 and 09 reserved

37.108.510 QUALITY IMPROVEMENT (1) By October 1 of each year, the health carrier shall provide documentation on its quality improvement activities and an evaluation of the effectiveness of the previous year's quality improvement activities. Such documentation must include the health carrier's identification of quality assessment problems and opportunities for improving care through:

(a) ongoing monitoring of process, structure, and outcomes of patient care or clinical performance;

(b) evaluation of the data collected from ongoing monitoring activities to identify problems in patient care or clinical performance using criteria developed and applied by health care professionals;

(c) measurable objectives for each improvement action within the reporting year, including the degree of expected change in persons or situations;

(d) time frames for quality improvement action; and

(e) parties responsible for implementing quality improvement action. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-303, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.511 CLINICAL FOCUSED STUDY (1) The health carrier shall conduct a focused study relevant to the quality of its services for enrollee care. The health carrier must document the clinical focused study and submit it to the department by October 1 of each year.

(2) The health carrier shall select topics for the focused study that are justified based on any of the following considerations:

(a) areas of high volume;

(b) areas of high risk;

(c) areas where problems are expected or where they have occurred in the past;

(d) areas that can be corrected or where prevention may have an impact;

(e) areas that have potential adverse health outcomes; and

(f) areas where enrollee complaints have occurred.

(3) The health carrier shall document the study methodology employed, including:

(a) the focused study question;

(b) the sample selection;

(c) data collection;

(d) evaluation criteria; and

(e) measurement techniques. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-303, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

Rules 12 through 14 reserved

37.108.515 ENROLLEE COMPLAINT SYSTEM (1) The health carrier shall have an internal complaint system for enrollees. Such a system shall comply with the requirements of 33-31-303, MCA, and ARM 6.6.2509(4).

(2) The health carrier shall conduct ongoing evaluations of all enrollee complaints, including complaints about the health carrier's services filed with participating providers. Ongoing evaluations must be conducted in accordance with ARM 37.108.510. The data on complaints must be reported and evaluated by the health carrier at least quarterly.

(3) Evaluation methods must permit the health carrier to track specific complaints, assess trends, and establish that corrective action is implemented and effective in improving the identified problem(s).

(4) The health carrier shall document and monitor the effectiveness of its evaluation of the enrollee complaint system and communicate it to the involved providers, enrollees, and the department upon request. The information is subject to the confidentiality requirements provided in 33-36-305, MCA. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-303, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.516 RECORDING CONSUMER SATISFACTION (1) The health carrier shall record consumer components that identify enrollees' perceptions on the quality of the health carrier's services, including:

(a) enrollee satisfaction surveys; and

(b) enrollee complaints, including:

(i) the health carrier's resolution of the complaints through its internal procedures;

(ii) independent peer reviewers' decision pursuant to 33-37-103, et seq., MCA, and ARM 37.108.301, et seq.;

(iii) arbitration decisions; and

(iv) court decisions.

(2) The health carrier shall submit documentation of its handling of consumer satisfaction to the department by October 1 of each year.

(3) The health carrier may meet the requirements in (1)(a) of this rule regarding enrollee satisfaction surveys by submitting to the department the information required for network adequacy as specified in ARM 37.108.201, et seq., as long as the information is consistent with what is required in (1)(a) of this rule.

(4) The identities of enrollees involved in recording consumer satisfaction are subject to the confidentiality requirements provided in 33-36-305, MCA. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-303, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

Rules 17 through 19 reserved

37.108.520 CORRECTIVE ACTION (1) The department may recommend corrective action to the health carrier in the event that the health carrier fails to comply with this subchapter.

(2) If a health carrier fails to implement adequate corrective action, the department will provide the commissioner of insurance with documentation of the health carrier's inadequacy. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-105 and 33-36-401, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

37.108.521 INFORMAL RECONSIDERATION OF DEPARTMENT DECISION (1) If a health carrier is aggrieved by a decision by the department pursuant to Title 33, chapter 36, part 3, MCA, and these rules, the health carrier may request an informal reconsideration of the department action as provided in ARM 37.5.311.

(2) The informal reconsideration includes:

(a) written notice to the health carrier of the department action and the findings upon which it was based, if not otherwise already provided;

(b) the health carrier's written refutation of the department's findings, which must be received by the department within 15 days after mailing of the department's notice under (2)(a); and

(c) the department's written determination modifying, affirming or reversing its decision.

(3) Any informal reconsideration under this rule is not subject to the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA. (History: Sec. 33-36-105, MCA; IMP, Sec. 33-36-401, MCA; NEW, 2001 MAR p. 1342, Eff. 7/20/01.)

Chapters 109 through 115 reserved